PROJECT ABSTRACT

Project Title: CT Maternal, Infant and Early Childhood Home Visiting Program
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Problem: High rates of poverty, homelessness, crime, domestic violence, maternal depression, child maltreatment, substance abuse, and teen parenting negatively affect parenting, maternal and child health, child development, and school readiness. The MIECHV grant program will support and improve high quality evidenced based home visiting services that have been shown to improve the health and development of children and parenting capacity. Connecticut (CT) will 1) Implement voluntary, evidenced-based home visiting programs; 2) Provide high quality home visiting services to families residing in at risk communities; 3) Target outcomes specified in the authorizing legislation to improve the well-being of children and families. To achieve this, CT will continue grant funding for its MIECHV Parents as Teachers (PAT), Early Head Start (EHS), Nurse-Family Partnership (NFP) and Child First model home visiting programs. PAT, EHS, and NFP provide parenting education and comprehensive family support for families at risk while the mother is pregnant or shortly after the birth of the baby, through age five. The PAT program has been enhanced with a focus on fathers and mothers' intimate partners. Child First provides intensive psychotherapy and case management services for families with vulnerable children. Services can be provided for families during pregnancy and through the first five years. Child First focuses its outreach to high risk and hard to reach families. The total proposed caseload of family slots— i.e. the number of families proposed to be served throughout the time period— for the final six months of FFY 2016 is 947. For fiscal year 2017 the proposed caseload of family slots is 1,086 per year, and for FFY 2018, it is 883 slots. The current number of families enrolled statewide as of December 31, 2015 is 747. CT will provide home visiting in the following high risk communities with unmet need: Ashford, Bloomfield, Bolton, Bridgeport, Bristol, Canterbury, Colchester, Danbury, Derby, Eastford, East Hartford, East Haven, Fairfield, Griswold, Hartford, Killingly, Lisbon, Manchester, Mansfield, Meriden, Milford, New Hartford, New Haven, New London, North Branford, Norwich, Plainfield, Putnam, South Windsor, Southington, Sprague, Sterling, Stratford, Torrington, Trumbull, Vernon, Wallingford, Waterbury, West Hartford, West Haven, Winchester, Windham and Windsor.

Staff at the State Office of Early Childhood (OEC) will coordinate with appropriate health, human services and educational entities to achieve the goals of the MIECHV program. It will coordinate outreach and enrollment among home visiting services within the participating communities, engage other partners in the coordination of early childhood services, and maintain a referral network for families to other services.

Annotation: This project will sustain evidenced based home visiting programs in CT serving high risk communities to address the problems adversely affecting parenting and child outcomes.

INTRODUCTION

The Purpose: The purpose of the MIECHV grant program is to support the delivery of coordinated and comprehensive home visiting services to families residing in high risk communities. Twenty two local implementing agencies (LIA) which have been shown to be effective in implementing the MIECHV program will provide services under this grant. The LIAs will implement evidenced based home visiting models to improve outcomes for children and families who reside in high risk communities.

Goals and Objectives: This grant program will support high quality evidenced based home visiting services that have been shown to improve the health and development of children and parental capacity. CT will: 1) Implement voluntary high quality evidenced based home visiting programs; 2) Provide the services of the home visiting programs to families residing in at risk communities; and 3) Target outcomes specified in the authorizing legislation to improve the well-being of children and families including improved health, safety, child development, school readiness, and the coordination of referrals and community services.

To achieve this, Connecticut will continue grant funding for its MIECHV Parents as Teachers (PAT), Early Head Start (EHS), Nurse-Family Partnership (NFP) and Child First model home visiting programs. PAT, EHS, and NFP provide parenting education and comprehensive family support for at risk families while the mother is pregnant or shortly after the birth of the baby, through age five. The PAT program has been enhanced with a focus on fathers and mothers' intimate partners. Child First provides intensive psychotherapy and case management services for families with vulnerable children. Services can be provided for families during pregnancy and through the first five years. Child First focuses its outreach to high risk and hard to reach families.

Progress: Significant progress has been made toward implementing high quality home visiting in the State of Connecticut. Efforts have focused on developing partnerships that support recruitment and enrollment, family safety, and trainings to enhance workforce effectiveness, benchmark improvement, and site development.

Collaboration with early childhood partners: Efforts with key partners are described below:

- **Connections Memorandum of Agreements for recruitment and referrals:** MIECHV programs entered into formal agreements with the state-funded Parents as Teachers programs that feature designated staff within birthing hospitals and other referral sources, call Nurturing Connections. These agreements allow the Connections staff to share the contact information of interested families with the MIECHV network of home visiting programs and provide a systematic approach to recruitment and referrals.
- **Department of Children & Families procedures for safety assessments and family team meetings**: Significant progress has been made in the OEC partnership with the state's child welfare agency, DCF. The DCF administrator for clinical and community consultation provided information at a meeting with MIECHV LIAs. The meeting covered the various child welfare programs available to families, the referral and risk assessment process, and its new family team meeting structure for enhancing coordination and communication with the

provider community and DCF involved families.

- **Domestic violence training:** All MIECHV home visiting LIAs attended a full day training with the state's coalition against domestic violence. This training included information on warning signs, safety planning, and resources.
- **Local advisory boards:** The MIECHV LIAs have local advisory boards that meet regularly. The advisory boards include representatives from health and human services organizations and others from the community. The advisory boards ensure that the LIAs have strong community connections and links to community partners for referrals and other collaborative efforts.

Training and professional development: The two MIECHV-funded program liaisons became certified Family Development Credential trainers in September 2014, Brazelton's Touchpoints trainers in March 2015 and attended Nurturing Family in Action trainings throughout the summer of 2015. This experience has positioned them to provide training in these program areas to the LIA home visiting staff.

Benchmarks Improvement: After being unsuccessful at meeting the benchmark requirements with the 2014 data, Connecticut focused on improving and passing the benchmarks for the 2015 data submission. To support the LIAs, the OEC hosted trainings that clarified constructs, definitions, data entry goals and focused on benchmark constructs that were commonly missed. In the summer of 2015, home visitors and clinical supervisors were brought together separately to brainstorm best practices in data collection and identify areas of confusion. The information gathered at these meetings provided our epidemiologist content for a benchmark toolkit. The toolkit was rolled out to program staff within all models in trainings. Additionally, program staff was required to attend trainings on domestic violence, working with multiple children and working with DCF involved families. In the next few months, the OEC will provide training for home visiting staff on accessing health insurance to ensure that they have the resources to do everything possible to help their eligible families become insured. The state as a whole, as well as each program model individually, met the benchmark requirements for 2015.

Site development: Continuous Quality Improvement across the MIECHV programs this past year focused on the benchmarks. Sites reviewed their individual data and identified areas in need of improvement. Sites submitted CQI plans that included proposed steps to be taken to meet goals. These CQI plans were reviewed and approved by the epidemiologist and program liaisons and were the focus of the annual site visit.

Local Implementing Agency (LIA) site visits were completed with all program models in December 2015. Site visits with the Parents as Teachers and Early Head Start LIAs focused on program CQI progress and program improvement goals, whereas visits with the Child First LIAs and the Nurse-Family Partnership program provided an opportunity for the OEC to gain a better understanding of the model and how the theory is translated into practice. Moving forward, all MIECHV models will be using a Result Based Accountability (RBA) framework and submitting Individual Program Plans (IPP) that will identify their goals for the next program year. The IPPs will then be used as the structure of the 2016 site visits to identify progress as defined by the RBA framework: how much was done, how well was it done, and was anyone better off because of the program.

Staff Development: In addition to the required model developer trainings, a number of other trainings were offered to staff. Parents as Teachers staff attended OEC's Nurturing Families in Action training. These are a series of training tracks for home visitors, clinical supervisors and program managers that explore each specific role. Staff have also been trained in Brazelton's Touchpoints model, which is a strength based approach that brings together curriculum, parent-child interaction and child development. Parents with Cognitive Limitations, a training offered in collaboration with DCF and other state agencies was also offered this past year to home visiting staff.

The results of the efforts:

- Site enrollment as of December 31st, 2015 was 747, or at 94% capacity state-wide.
- The LIAs are at 97% staffing capacity. Currently there are 4.5 FTE vacancies state-wide.
- 100% of existing staff are trained in their respective model curricula. When new staff are hired they are registered for the next available training.
- 100% of MIECHV-funded sites showed significant improvement in the benchmarks for 2015, compared to 2014.
- The six month retention rate for three of the four home visiting programs (PAT, EHS and NFP) for 2014 was 62%. In other words, of all families who enrolled during calendar year 2014 (604 families), 374 families or 62% were enrolled six months later. Among Child First programs, 134 of 199 families or 67% of families enrolled in 2014 were still enrolled six months later. Retention and attrition will be looked at more closely under the current grant. Of particular interest will be tying retention rates to enrollment time periods that are meaningful to the model.

Proposed changes since the last application and rationale: There are a few changes to Connecticut FFY 2016 application since the 2015. Projects that will be completed this year or are not included in the 2016 application. These include the completion of the second phase of the evaluation of the fatherhood home visiting component of the Parents as Teachers program, the materials for the safe infant sleep campaign, training for home visitors in the use of Triple P, participation for fathering home visitors and fathers in the national fatherhood conference, and a MIECHV home visiting staff team building activity. In addition the proposal eliminates funds for the centralized call center. The call center has completed a project to assemble referral resources for pregnant women. The center and project will continue with state funds. Also, the duties and responsibilities performed by the health program associate for fiscal and contracts monitoring will be eliminated. These duties will be covered through the Central Contracts Unit, the OEC fiscal office and the OEC state funded Family Support Services Program Director. The State of CT Central Contracts Unit assigned to the CT Office of Early Childhood is responsible for managing the administrative, fiscal and contracting functions related to health and human service contracts. The OEC Family Support Services Division Director will assume overall responsibility for monitoring the financial aspects of the MIECHV program with a primary focus on sub-recipient contracts. She will be assisted by staff from the OEC business office.

History: Connecticut (CT) has a rich history of implementing high quality home visiting programs that are part of a comprehensive early childhood system. This history now includes a significant expansion of evidenced based home visiting under the MIECHV formula and

competitive grants. Under this expansion, the state established new programs in 23 implementing agencies. Through these and other efforts the state continues to make significant progress toward implementing a high quality home visiting services in the state.

Previous Steps: CT has taken many steps to develop its high quality home visiting program, beginning with state funding for two LIAs in 1995. Since that time, the state funded program, which uses the evidenced-based Parents as Teachers (PAT) model, has grown from 2 to 38 LIAs. The goal of these services is to address the underlying factors that make parents vulnerable to abusing and neglecting their children and, ultimately, to reduce the number of children substantiated by the child welfare system as abused or neglected. Today, the program provides services through all of the state's 29 birthing hospitals with expanded programs in two urban areas, Hartford and New Haven. Roughly 8,000 first-time mothers are screened at these hospitals each year, on the maternity ward, the prenatal clinics, and elsewhere in the community each year. Of those screened roughly 2,200 families receive home visiting services from approximately 125 home visitors every year, including 12 male home visitors who work specifically with fathers and mothers' intimate partners. Since its inception, the state-funded PAT program has provided comprehensive home visiting services to approximately 12,000 families. Under the CT MIECHV competitive grant the PAT program was expanded through 13 additional LIAs including hospitals, child guidance clinics, federally qualified health centers, family resource centers, city boards of education, city health departments and other community based organizations.

The Child First (CF) model was developed in Bridgeport, CT in 2001 as a community response to the needs of young vulnerable children and their families, especially children with emotional and behavioral problems. These children were living in families with many challenges, and were exposed to stress and trauma. Services are provided by a 'home visiting team' comprised of a master's-level licensed mental health clinician and a bachelor's-level care coordinator. A randomized controlled trial of Child First, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), demonstrated statistically significant and clinically significant benefits for the children and families that participated in CF compared to a comparison group. Child First began replicating the model in CT in 2010 in child mental health agencies and hospitals. Replication for the first 10 sites was funded by local and national philanthropy, grants from the State Department of Education (SDE) and the Department of Children and Families (DCF), and a Project LAUNCH grant from SAMHSA. Today these sites are sustained primarily with state funding through DCF. In 2013, Child First was replicated and expanded in eight locations with MIECHV competitive grant funding. With this combination of state and federal funding the Child First sites serve approximately 1,000 children per year.

Collaboration with state and other agencies: The CT Office of Early Childhood serves as the state's Child Care and Development Fund Administrator and the Head Start Collaboration Office. The CT Office of Early Childhood is the administrator for Healthy Start through an Memorandum of Agreement with the Department of Social Services (DSS). DSS is the state agency that administers TANF, WIC, SNAP, and the state's Medicaid/Children's Health Insurance program. The OEC Commissioner is the co-chair of the Connecticut Early Childhood Cabinet along with Lt. Gov. Nancy Wyman. She is also chair of the Cabinet's State Advisory Council subcommittee.

She is a member of the Two-Generation Interagency Working Group and participates on the Youth and Urban Violence Commission.

Staff from the Office of Early Childhood participates in the following workgroups and committees. Child Emergency Preparedness Committee: sponsoring agency, Commission on Children and CT Department of Emergency Services and Public Preparedness; CT Association of Infant Mental Health; CT Fatherhood Initiative: sponsoring agency, Department of Social Services; CT Parents with Cognitive Limitations Advisory Committee: sponsoring agency Department of Children and Families; Early Childhood Comprehensive Systems Advisory Committee: sponsoring agency, United Way; Family Violence Task Force: sponsoring agency CT Academy of Science and Engineering; Medical Home–Children & Youth with Special Healthcare Needs: sponsoring agency, Department of Mental Health; Parents As Teachers State Advisory Board: sponsoring agency ConnPAT; Strengthening Families Leadership Team; Substance Exposed Infants-Keeping Infants Drug Free; sponsoring agency DCF and DMHAS; Safe Sleep Campaign; sponsoring agency, DCF: sponsoring agency DSS; Ear.ly Childhood Cabinet–Focus on Homelessness; Safe Baby Court Team, sponsoring agency DCF; and the Interagency Collaboration Committee, supported by IDEA Part C.

In 2014, state legislation (Public Act 15-45) called for the Office of Early Childhood (OEC) to establish a home visiting consortium to advise the state on implementing several recommendations for coordinating the home visiting programs within the early childhood system. The recommendations include the development of: Common outcomes across programs; Shared reporting of outcomes and information on existing gaps in services; A core set of standards and outcomes for all programs including a monitoring framework; A core set of competencies and required training for all home visiting program staff; Coordinated training for home visitation and early care providers on cultural competency, mental health awareness, child trauma, poverty, literacy and language acquisition; Home-based treatment options for parents suffering from severe depression; and Intensive intervention services for children with mental, social or emotional issues. Membership on the consortium includes: individuals representing families who are receiving services or have received services within the last five years from one or more home visitation programs in the state; members representing home visitation programs in the state (Child First, Early Head Start, Birth to Three, Parents as Teachers, Minding the Baby), Family Resource Centers, United Way of Connecticut 2-1-1 Infoline; Birth to Three; Connecticut Head Start State Collaboration Office; Office of Early Childhood; Department of Children and Families (DCF); Department of Developmental Services (DDS); State Department of Education (SDE); Department of Mental Health and Addiction (DMHAS) Services; Department of Public Health (DPH); Office of the Child Advocate; Commission on Children.

NEEDS ASSESSMENT

At Risk Communities Served: CT will provide home visiting in the following high risk communities with unmet need: Ashford, Bloomfield, Bolton, Bridgeport, Bristol, Canterbury, Colchester, Danbury, Derby, Eastford, East Hartford, East Haven, Fairfield, Griswold, Hartford, Killingly, Lisbon, Manchester, Mansfield, Meriden, Milford, New Hartford, New Haven, New London, North Branford, Norwich, Plainfield, Putnam, South Windsor, Southington, Sprague,

Sterling, Stratford, Torrington, Trumbull, Vernon, Wallingford, Waterbury, West Hartford, West Haven, Winchester, Windham and Windsor.

Barriers: One of the barriers has been identified in serving families is language. State-wide, according to the 2000 census, 18% of Connecticut residents over the age of 5 spoke a language other than English at home. Among the families served in our programs during fiscal year 2015, fully 25% spoke a primary language other than English; 20% of that 25% represented Spanish-speakers. Similarly, 14% of residents state-wide reported being foreign born in 2000. Considering the towns that MIECHV-funded programs serve in Connecticut shows a range in the percentage of the population foreign born, from below the state average up to 29% in Bridgeport and 35% in Danbury. A new strategy that we propose to work with families whose primary language is not English, is to partner with agencies who work specifically with immigrant populations and other non-English speaking groups. Consulting with our state Help Me Grow organization yielded a wealth of information on potential partner organizations. Forty-six programs across the state work with Hispanic/Latino communities alone. Many of these services are located in or near the communities served by MIECHV. Additionally, 7 organizations were identified as providing ethnic-oriented multipurpose services, and an additional 8 were refugee resettlement programs across the state, further expanding both the geographic coverage and the potential services that the MIECHV program could partner with.

Target Sub-Populations: In addition to expanding the work with immigrant and non-English speaking families, it is a top priority of the OEC to increase the work being done with homeless families. Of the home visiting models in Connecticut, Child First (CF) is particularly well-suited to expand on this work, given their history and experience reaching very high need families. CF has consistently worked with families in unstable housing (23% of families have reported being without a place to live at some time, and 11% have moved 3 or more times in the past year), and living in shelters (15% reported having lived in a shelter). Child First is beginning a new collaboration with the CT Coalition to End Homelessness to focus increased attention on this population. The CF Care Coordinators are experienced and skilled at finding housing with scarce resources, while the CF Clinicians focus on underlying issues which have contributed to the instability– both emotional and physical challenges. Child First has experience finding stable housing for families, ensuring adequate concrete resources (furniture, cookware, blankets, clothing), means of financial support, and working with parents to maintain the focus on nurturing and supporting their children in the midst of upheaval. Child First's two-generation psychotherapeutic intervention is critical to the progress that families make toward developing productive and stable lives.

Title V Needs Assessment: There are extensive connections between Connecticut's Title V needs assessment, and the goals and activities of MIECHV-funded home visiting. There is an active Maternal Child Health Coalition in Connecticut comprised of professionals from various settings, including government agencies, local health departments, health care facilities, non-profit organizations, educational institutions, and business. Led by the Department of Public Health, this coalition completed a State Health Assessment and a State Health Improvement Plan in 2015. These documents in turn, and the significant investment that went into them, informed the development of the Title V needs assessment, published in June 2015.

Many of the findings and goals of the needs assessment align directly with the goals of MIECHV. The needs assessment highlighted teen births, timely and adequate prenatal care, pre-term birth, and infant mortality—each especially as they are disproportionately represented among racial and ethnic groups, and geographically throughout the state. Breastfeeding, preventive medical care for infants and children, and childhood injuries were also among the topics and challenges outlined in the needs assessment. To address the issues set out in the needs assessment, the state-wide Maternal Child Health Coalition continues to meet and has formed three subgroups, focused on women's health, infant mortality, and child health, respectively. Staff from the Family Support Services Division at the OEC attend the full coalition meetings and two of the subgroup meetings. Each subgroup is in the process of developing action agendas; two initiatives under consideration which may relate directly to the work of the home visitors are the One Key Question Initiative, and the IMPLICIT Network.

Unmet Need: The need for home visiting in Connecticut is enormous, and the biggest limitation in serving all eligible families is resources. In 2010, 14,477 children were born into poverty in Connecticut; about half of those (7,212 children) came from families living in cities and towns currently served by MIECHV–funded programs. By comparison, the state-wide yearly capacity proposed here is just over one-thousand (1086). There were more than 505 births to teenage mothers living in MIECHV communities in 2012. Similarly, at least 929 babies were born to mothers residing in MIECHV communities with late or no prenatal care and another 1881 were born with non-adequate prenatal care. The number of families served in fiscal year 2015 exceeded the yearly caseloads as predicted by the models; 1370 families were served compared to an expected number of 1086 families. Still, it is not possible to reach all families that could benefit from services with existing resources.

METHODOLOGY

Goals and Objectives: The MIECHV grant program will support high quality evidenced based home visiting services that have been shown to be effective for improving the health and development of children and parental capacity.

OBJECTIVE 1: Implement voluntary high quality evidenced based home visiting programs

Activity 1: Implement evidenced based home visiting models that address the major problems facing families in CT.

There is no single problem facing the vulnerable families in CT, instead there are a multitude of challenges that negatively affect parenting, maternal and child health, child development, and school readiness. In 2010, the State Department of Public Health (DPH) conducted a statewide needs assessment for the MIECHV grant program. It found that CT had high rates of poverty, unemployment, homelessness, crime, domestic violence, maternal depression, child maltreatment, substance abuse, and teen parenting. Since that time these problems have not abated. In fact, there are roughly 12,000 children born into poor families each year with one or more risk factors for abuse or neglect or poor child development. About 5,000 children are born

to first time parents with roughly 2,200 are born to teens. About 12% of the mothers receive late or no prenatal care (CT Voices, 2013). In 2013, 15% of children were living in poverty and the number of Black and Hispanic children below 200% of poverty was roughly 155,000. The number of women and children receiving WIC (Women, Infants and Children supplemental nutrition program) was 54,284, and the number of children enrolled in Medicaid and CHIP was 333,231. Demographic data shows that the proportion of children at risk due to poverty varies greatly across CT, from less than 1% in some suburban communities to 20% in the urban periphery and rural areas, and more than 38% in the urban communities. Examples of these outcomes include:

- A high rate of premature births (8 percent) and low birth weight babies (10 percent): Rates are 4 percent higher among racial and ethnic minority groups. (Kids Count Data Base 2014).

- The widest gap in the country for educational performance between its poor and wealthy students: The gap disproportionately affects minority students, primarily African-American and Latino children. National progress tests given to fourth and eighth graders show that poor students in CT performed at dramatically lower levels than their wealthier peers—sometimes up to three grade levels behind (CT Education Reform, Inc. 2014).

- High rates of substantiated child abuse and neglect: The Care Line at the state child welfare agency received over 96,000 calls in state fiscal year 2013. Fifty percent of these reports involved suspected abuse or neglect, of which over 50 percent were accepted for investigation, and approximately, 6,800 were substantiated (DCF Town Pages 2014).

To address these challenges CT determined that it needed home visiting models that would support family need across the continuum of prevention and intervention services. CT chose three prevention-focused and one intervention-focused model. PAT, EHS and NFP are primary prevention-focused and offer parenting education and comprehensive family support. Child First is intervention-focused and provides parent-child psychotherapy and care coordination. Together these models support the future growth and development of all children. They address maternal and child health, child safety and child maltreatment, family safety and domestic violence, economic self-sufficiency, and provide a connection to community resources and services. A description of each model follows.

Parents as Teachers Model: The goal of the program is to address family expectations, strengths and needs in the following target areas**:** Development Centered Parenting addresses developmental topics such as sleep, attachment, nutrition, discipline, routines and transitions, safety and health throughout the child's development; Parent Child Interaction provides opportunities to encourage quality interactions between children, parents and other family members; Family Well-Being encourages families to provide healthy environments for parent and children to grow and develop, nurture relationships, and strengthen social-emotional development; Healthy Families promotes the overall health and wellness of families including their physical, social, cognitive and emotional well-being; Parent Life Outcomes promotes parents in achievement of personal and family goals. The PAT model is curriculum based. It stresses the unique developmental needs of both the parent and child during each stage of the child's development.

Early Head Start–Home Based Option: The Ansonia/Derby community identified the Early Head Start program as meeting the needs of the community; a home visiting model designed to provide high quality child and family development services to low-income pregnant women and families with infants and toddlers (birth to age three years). The program focuses on cognitive development and school readiness by providing stimulating and educational activities for the poor children served by the program. The EHS program also uses the PAT curriculum and the ASQ screening tools, as well the reflective supervision model.

Nurse-Family Partnership (NFP): The NFP model has shown evidence of successful outcomes in maternal health, child health, child development and school readiness, reductions in child maltreatment, reductions in juvenile delinquency, family violence and crime, positive parenting practices, and family economic self-sufficiency. Skilled nursing visits include information and coaching in prenatal care, infant care, coaching in activities to promote the emotional, physical, and cognitive development of young children. Nurses also work with the mothers to set personal and family goals to increase family economic self-sufficiency. The program provides home visits every two weeks for up to two years. The nurses focus on assisting families to gain access to child and maternal health services, promoting child development and school readiness, and helping parents address issues that would increase the risk of child maltreatment by teaching positive parenting practices.

Child First Model: Child First is an intensive home visiting mental health intervention that ameliorates mental health, developmental, and learning problems, and prevents abuse and neglect. The program works with pregnant and postpartum women and children from birth to age six years who have emotional and behavioral issues, and who face risks that may threaten healthy development (e.g., maternal depression, domestic violence, homelessness, parental substance abuse, and/or other traumatic events). Child First is a dyadic intervention that focuses on the relationship between the primary caregiver (mother, grandmother, foster parent, relatives) and one or more identified children in the home. The model intentionally works with the whole family to create a safe, nurturing environment. The Child First model is based upon neuroscience findings on "toxic stress," including the long term health effects of adverse childhood experiences (ACEs) and the impact of environmental stress on early brain development. The Child First model works to decrease the source of this stress and enhance the quality of the relationship between parent and child. Specifically, a nurturing, responsive, parent-child relationship in which a child feels loved, valued, and safe, is able to mitigate the potentially devastating effects of toxic stress on both brain and body, promoting child emotional wellness, cognitive capacity and executive functioning, and physical health. Child First visits are structured with teams, with each team consisting of a care coordinator and a mental health clinician. The teams generally visit the families weekly for six to twelve months, though visitation may be markedly increased depending on the needs of the family.

Activity 2: Ensure the best outcomes for families by providing family-centered home visiting and reaching out to engage the most socially isolated families.

To ensure the best outcomes for children and families participating in these programs the PAT LIAs will focus on engaging residential and non-residential fathers and mothers' intimate

partners in home visiting. The services will focus on gender related matters including employment and education, the father's sense of himself as a leader within his family, and as a nurturing father to his child.

Child First will reach out to high risk and hard-to-engage populations to find families in need of services that are otherwise likely to 'fall through the cracks'. Child First is experienced in working with families who have experienced trauma and are under very high levels of stress. Included among the very high risk, high need families that Child First has served, and will expand services to, are homeless families. Child First will focus on finding and engaging these very high risk families who are socially isolated and living in the margins of the community.

Activity 3: Ensure that the models are well matched to the needs of the communities.

The home visiting models were originally selected by members of the communities where it was determined services would be provided. A review and update of the initial needs assessment has reaffirmed the match between community need and the program models. The DPH statewide needs assessment (2010) identified a set of community risk factors that established the need for programming. For PAT, EHS and NFP the assessment considered unemployment rates, rates of low birth weight babies, and rates of non-private health insurance at birth. For the Child First program, it looked at the percent of young children living in poverty, low third grade school achievement, high school dropout rates, and exposure to abuse and neglect.

The update focused on data that would identify where the priority populations for the MIECHV grant reside. The update examined the communities identified in the initial needs assessment and in surrounding suburban and rural communities where poverty has been spreading and reclustering in CT–areas where the need for services is very high. Since the PAT, EHS and NFP programs work primarily with pregnant women and new mothers and their families, data on teen births and births to mothers on public insurance were reviewed. The most recent data confirms that the need for PAT remains high in the communities currently served and found communities of high risk and unmet need in the surrounding towns. For Child First, review of the most recent data included the number of children receiving free or reduced price lunch and the number of families on public insurance. The data indicate that the need continues for Child First in the communities it is serving and found communities of high risk and unmet need in the surrounding towns. The PAT, NFP, EHS, and Child First programs will be providing services in the communities they currently serve and in the surrounding towns.

Efforts to further update and fine tune the needs assessments are described later in this application.

Activity 4: Implement models that can be implemented with fidelity and provide the best opportunity to meet the benchmarks.

The CT program has shown that it is capable of delivering high quality services that meet model fidelity and the benchmark goals. Each of the 23 LIAs implementing the four program models has been re-accredited by its model developer for meeting the model requirements for fidelity and program performance. In addition, each of the 23 LIAs has met the benchmark goals.

The state has developed a data system that measures the progress of the PAT, NFP and EHS LIAs toward the benchmarks. Child First maintains its own data system for this purpose.

Activity 5: Issue contracts for the implementation of the home visiting program models.

CT will sustain its contracts with 13 LIAs to implement PAT, 8 to implement CF and 1 each for EHS and NFP. These providers were selected through community forums attended by members of the community where the sites are located. Each of the contractors has met the benchmark goals and has been re-accredited by their respective model.

OBJECTIVE 2: Provide the services of the home visiting programs to families residing in at-risk communities

Activity 1: Ensure that services are voluntary through collaboration with the DCF.

Family participation in all programs is voluntary. Connecticut ensures that MIECHV services are voluntary through training of home visiting staff, ongoing communication and collaboration with the CT Department of Children and Families and through written policy and procedures. Connecticut has a current policy that states, participation is always a voluntary service and cannot be stipulated as a mandated service or as an alternative to a CT Department of Children and Families investigation or for ongoing oversight and intervention related to child abuse and neglect.

Due to the relatively high proportion of families who are already involved with DCF when they come to the program, this is a particular challenge for the Child First program, and staff have developed ways to ensure that involvement is voluntary. After referral, Child First teams have a protocol which includes persistent efforts to contact and enroll these often hard-to-reach families with multiple phone calls, letters, and notes at their doorstep. Child First staff will meet parents wherever they are most comfortable, including a pediatric appointment, child care, worksite, or restaurant in the community. This outreach can last 4 to 6 weeks. From the first encounter, families are told that services are voluntary, that the program is different and separate from the state's child protective services at DCF, and that the goal of the program is to help them with their own goals and priorities. If caregivers indicate that they are not interested, the staff closes the case, even in instances where DCF has made the referral. Child First staff lets the family know that if they change their mind they may enroll at any time. Families are given a card with the contact information. When a family begins services, the Child First team spends a month working with the family to do a comprehensive assessment in order to fully understand their needs and priorities and jointly to design a Child and Family Plan of Care.

Activity 2: Maintain recruitment and referral agreements with state.

Outreach and recruitment of participants to the local PAT, NFP and EHS programs will be coordinated through the Nurturing Connections staff at the state-funded NFN programs The MIECHV PAT, EHS and NFP LIAs have entered into formal agreements with the NFN Connections programs. Through this effort the Connections staff reaches out to families in

hospitals and health care provider offices and within the community to introduce and offer the MIECHV program services. Child First receives its referrals primarily through the child welfare system, pediatric practices, mental health agencies, and preschools. This year Child First will focus on outreach to homeless shelters and other families who are socially isolated. All MIECHV programs are also engaged in local outreach efforts with health and human services organizations in their communities and receive referrals from these sources. In addition, the CT Help Me Grow (HMG) program also refers families and children to the MIECHV LIAs. HMG is a statewide call center that can be accessed by health and human service providers and families through a 1-800 number. More than 2,200 parents are referred to Help Me Grow when they have a concern about how their child is learning, developing or behaving. Through HMG, a family's need is assessed and they are connected to the programs and services that best meet those needs. Dual enrollment is avoided by including language in LIA contracts that does not allow dual enrollment in MIECHV programs and discussing this policy with all contractors, by determining through the family assessment if the family is participating in additional home visiting services and by using the MIECHV database to identify duplication.

Activity 3: Focus effort on retention.

A primary focus of CT's efforts in 2016 will be on retention. A highly transient population, at times suspicious of social service providers–especially those working with the child protective services agency, relatively new home visiting programs and staff, and staff turnover, have each posed challenges to enrollment and retention. OEC staff will be looking at retention data closely, for each LIA, and discussing individual data and trends with LIA staff, including strategies that they can then incorporate into their individualized program plans. We will also incorporate retention into the home visiting network as a whole (combined federal and state-funded home visiting) through the Continuous Quality Improvement (CQI) process. The over-arching goal will be to develop strategies to improve the number of home visits to each family and their length of stay in the program, particularly as it relates to program and family-specific goals. In addition, programs will re-engage families when appropriate. Families may re-enroll in the home visiting program at any time. Program staff will meet with families interested in re-enrolling to reassess their needs and will offer families the opportunity when possible to work with their previous home visitor or begin working with a new home visitor if the family so desires. For 2014, the six month retention rate for three of the four home visiting programs (PAT, EHS and NFP) was 62%. In other words, of all families who enrolled during calendar year 2014 (604 families), 374 families or 62% were enrolled six months later. Among Child First programs, 134 of 199 families or 67% of families enrolled in 2014 were still enrolled six months later.

Activity 4: Ongoing professional development and a system of training for home visiting staff are an essential component of program development and the ability of the programs to retain and effect positive change for families.

Ongoing professional development and a system of training staff is an essential component of program development. CT provides a well-structured comprehensive training program for MIECHV LIA staff. The training enhances both the quality of the home visiting service and the skills of the home visitors in their challenging work with families. The training programs offered

by the program models and augmented by the OEC are described below.

PAT and EHS Training: Comprehensive training for MIECHV PAT and EHS (which uses PAT) program staff is divided into two tiers. The first tier includes trainings that support and enhance skills around curricula as well as the recruitment, engagement, enrollment and retention of families. It is completed in first 18 months of employment. The second tier of training is designed to further enhance both the quality of the home visiting service and the skills of the home visitor around working with families with complex issues.

Tier 1 Training: Training is interactive and experiential based on the adult learning theory, to prepare staff for their roles and responsibilities (Speck, 1996). The training covers theories of attachment and maternal bonding, and stages of child development; the theory and practice of reflective supervision and group process; approaches to prevent shaken baby syndrome based on the Period of Purple Crying model developed by Dr. Ron Barr (Barr, 2011); skills for screening using Ages and Stages Monitoring Questionnaire and Ages and Stages Social and Emotional Questionnaire. The training also includes Family Development Credential (FDC) for Family Workers and Leaders that teaches strategies for staff to assist families to build on their strengths and to develop a healthy self-reliance and interdependence with others in their community; Touchpoints –focused on the developmental and relational elements of the parent-child-provider relationships, and their practical applications; the unique role of fathers in families including their strengths and risks and includes: parenting issues faced by fathers, engagement strategies for co-parenting and family dynamics, parenting skills and child development, skills to encourage parent-child interaction, finding resources for fathers, and the development of plans that address the role of fathers and other males in the home.

PAT and EHS Tier 2 Training: Training includes Identifying and Working with Parents with Cognitive Limitations that assists providers to recognize how their own values and beliefs about parents with cognitive limitations impact their work and understand how cognitive limitation are seen from a functional perspective; Self and Others focuses on their own life, history and culture while learning about others including group dynamics and the stages of human development; multiculturalism for home visitors explores bias and prejudice in the American experience, forces that perpetuate it and forces for change including history, poverty, religion, spirituality, immigration and others; complex Human Behavior explores substance abuse, domestic violence and behaviors related to mental health issues, grief, trauma, teen pregnancy and family planning.

Child First: Child First, Inc. provides training through a Child First Learning Collaborative to prepare staff for their roles. The structure is a combination of intensive Learning Sessions four face-to-face trainings, Learning Sessions over 12 months, trauma-informed Child-Parent Psychotherapy training (three face-to-face sessions and consultation over 18 months), modules of guided on-line, Distance Learning, and the ongoing provision of reflective clinical consultation by expert senior clinical consultants. The Learning Sessions include the basic components of the model (the process of engagement, assessment protocol and measures, case formulation, treatment planning, child-parent psychotherapeutic intervention, scaffolding of executive functioning, use of video in intervention, and termination), data collection, and intensive, reflective, clinical supervision. The training also includes the theoretical underpinnings around toxic stress and ACEs, early brain development, typical child development and developmental challenges, attachment and early childhood mental health, , substance use, maternal depression,

domestic violence and more. It includes observations of typical development (in the field) and challenging behavior (video) and exercises to consolidate the knowledge.

In addition, Child First has extensive required Foundational Readings that are available to all staff at the point of hire with subsequent discussion during supervision. The Child First Training Department continues to develop online Distance Learning materials that are required for all staff. These online learning modules are particularly useful to new staff hired between Learning Collaboratives when there is less access to in-person trainings. The material covered in the Distance Learning spans History and Development of Child First, Attachment Theory, Trauma Core Concepts, Assessments Tools, etc. and is accompanied by discussion questions.

Reflective, clinical supervision and consultation are essential components of providing the Child First intervention with fidelity and include case presentations, formulations, use of process notes, and review of video of actual sessions. The senior clinical consultant from Child First, Inc. meets with new sites on a weekly basis initially, progressing to biweekly, and is ongoing to insure high quality clinical services and model fidelity.

Reflective clinical consultation is an essential component of providing the Child First intervention with fidelity and includes case presentations, formulations, use of process notes, and review of video of actual sessions. The senior clinical consultant from the Child First, Inc. meets with new sites on a weekly basis initially, progressing to biweekly, based on the rate of integration of the new staff. As soon as new teams complete the first Learning Session, they begin to work with families. Initially they carry a reduced caseload of families, and build up to full capacity within six months. In addition to the formal Learning Collaborative, Child First provides up to four special trainings a year and an annual conference.

Nurse-Family Partnership Training: Nurse-Family Partnership Supervisor Initial Education Units: Supervisor Unit One is a series of lessons that take approximately 20 to 30 minutes to complete. The lessons are designed to orient a supervisor to her/his role and responsibilities in the Nurse-Family Partnership program and concentrate on program logistics, including agency setup, documentation, referrals, and hiring nursing staff. Unit Two is a five day face-to-face session preparing new nurses to implement the intervention with fidelity to the Nurse-Family Partnership model. Providing interactive learning where nurse home visitors receive instruction and assistance to begin applying information and building skills in the Nurse-Family Partnership intervention. The Supervisor Unit Three training is distance education sessions focused on Nurse-Family Partnership implementation issues, provides the supervisor with support in assessing the quality of nursing practice and implementation, and supports the professional development of nurse home visitors. A lesson is included to help supervisors learn how to connect with their community to sustain and grow their program. Supervisor Unit Four is face-to-face three-day session occurs approximately four to six months after completion of Unit Two. The session again focuses on the Nurse-Family Partnership model to promote supervisor skills around teambuilding and job stress and burnout. It also builds on reflection and motivational interviewing skills learned in earlier sessions.

Nurse-Family Partnership Initial Education Units: This initial education series will equip newly hired nurses and supervisors with foundational knowledge of Nurse-Family Partnership

and the home visiting intervention. Unit One is a distance education session comprised of two components: completion of the Unit One workbook and online self-assessment, and completion of the online lesson using the NFP Visit-to-Visit Guidelines. Unit One workbook and corresponding assessment is a 30 to 40 hours on this self-study module. Unit Two is a five-day face-to-face session and is required for all new, expansion, and replacement Nurse-Family Partnership Nurse Home Visitors preparing new nurses to implement the intervention with fidelity to the Nurse-Family Partnership model. Providing interactive learning where nurse home visitors receive instruction and assistance to begin applying information and building skills in the Nurse-Family Partnership intervention. Unit Three provides nurses an opportunity to deepen their understanding of the Nurse-Family Partnership model, specifically in regards to infant temperament, motivational interviewing, and fidelity to the Nurse-Family Partnership Model Elements. Staff will consult with their supervisor regarding the best time to start the Unit Three distance lessons. The distance lessons will take approximately one to two hours per month over a six-month time frame.

All new, expansion, and replacement supervisors are required to attend Nurse-Family Partnership Nursing Supervisor Units One through Four and Nurse-Family Partnership Nursing Units One through Three. If a supervisor is promoted from nurse home visitor and it has been over two years since initially completing Nurse-Family Partnership Initial Education, the promoted supervisor is required to complete Supervisor Units One through Four as well as Units One through Three. If a nurse home visitor returns to Nurse-Family Partnership after having not practiced in NFP for two or more years, the nurse home visitor is required to complete Nursing Units One through Three.

Activity 5: The OEC will enter into a Memorandum of Agreement (MOA) with several state agencies to foster referrals and the coordination of services.

The OEC will enter into a MOA with the United Way of Connecticut -Early Childhood Comprehensive Systems, the state Departments of Education - Individuals with Disabilities Education Act (IDEA) Part B, Children and Families -child protective services agency and Public Health – Title V. The MOA will address coordination and collaboration regarding referrals, screening, follow-up, and data. The OEC is home to Title 2 of CAPTA, IDEA Part C, and the state's pre-kindergarten program.

OBJECTIVE 3: Target outcomes specified in the authorizing legislation to improve the well-being of children and families including improved health, safety, family well-being, child development and school readiness, and the coordination of referrals and community services

Activity 1: Focus on the implementation of the benchmarks plan.

CT will review the results of the benchmark data for the state as a whole and for each LIA individually, on a quarterly basis. Feedback will be provided to each LIA for their use in their continuous quality improvement and individualized program improvement plans. Progress on the plans will be tracked and ongoing issued will be discussed and addressed.

Activity 2: Work with partners to support home visiting programs in meeting targets in

specialized areas.

In order to assist the LIAs in meeting the benchmarks, the OEC will incorporate training on specialized topics not sufficiently covered in the model or with existing supplemental training. The topics will include safety planning in domestic violence situations, health care insurance information and enrollment procedures, and working with complex family systems and families with multiple children. Because health insurance coverage is a benchmark measure, significant effort will continue to be made not only in training home visiting staff on how to ensure that their families are covered, but in tracking the percentage of families who are enrolled, and the progress that is made.

Activity 3: Outreach by the LIA advisory committee–candid conversations.

CT is planning to host conversations this year within the MIECHV communities to foster communication between providers and the broader community. The conversations will be hosted by the LIAs. Families, community providers, and government officials will be invited to participate. The purpose of the conversations will be to foster insight and understanding within the community of the broad and varied needs of families and the role the home visiting programs play in supporting families in meeting these needs.

Activity 4: Develop a proposal and secure a researcher at an academic intuition to assist the OEC and the CT Home Visiting Consortium, which serves as the state advisory committee for MIECHV, in making objective and informed recommendations to the state about the best use of the MIECHV funding.

CT is interested in contracting with a knowledgeable and objective academic institution to conduct a study and make recommendations regarding the needs of families in the state, the match between program models and family need, and the best possible continuum of services based on Connecticut's specific circumstances. The proposed study would be conducted by an academic institution familiar with the MIECHV program, the intervention and prevention literature, and the field of home visiting, including workforce, cultural, and program implementation considerations. Staff at the academic institution would review and analyze Connecticut-specific data, the randomized control studies that qualified each model for MIECHV funding, and model-specific performance within the state, including efforts funded by the state and philanthropy in addition to federally-funded. The study will include a review of updated data on Connecticut's communities, including demographic information, vulnerable populations, current resources and the distribution of agencies that serve families, and areas of unmet need. The purpose of the study will be to provide the state of Connecticut with information and recommendations that it can use to ensure the most effective use of the MIECHV funds.

Activity 5: Perform program and fiscal sub-recipient monitoring efforts on a regular and ongoing basis.

The OEC will monitor LIA compliance with federal programmatic and fiscal requirements. Programs will be monitored and assessed through a quality assurance system that includes quarterly program and fiscal reports, quarterly demographic and benchmark reports, regular

meetings with sites, and an annual site visit. The OEC staff will review all program, fiscal, and data reports on a quarterly basis. The OEC staff will conduct at least one site visit with each LIA and contractor each year of the grant funding. Individual Program Plans will be developed with each LIA following the site visits to address challenges and create plans for improvement. Technical assistance will be provided to help solve problems across the LIAs. Child First Inc. is under contract with the OEC to administer the Child First LIAs, and will review the progress of each LIA and provide technical assistance sessions with its sub-recipients.

Taken together, the review of quarterly reports, the site visit, and the ongoing communication and TA with LIAs will include:

- Reconciliation of budgeted expenditures to actual expenditures
- Monitoring and reviewing detailed expenditures for allowable expenditures
- Performing annual site visits to review financial and program operations - including but not limited to an assurance of enrollment and retention of eligible families in home visiting services, programmatic review of the performance of sub-recipients in implementation of the model with fidelity, and proper spending of funds
- Offering technical assistance when necessary
- Tracking report submissions

Activity 6: Planned technical assistance, training, and/or professional development activities provided by the model developers

NFP: The NFP National Service Office (NSO) will provide, at a minimum, a one hour phone call monthly with the VNA of Southeastern CT LIA to review reports such as the Estimated Total Enrollment and the monthly Operational Efficiency Dashboard, reflect on referrals, client retention, caseload management, etc. On a quarterly basis the NSO will review the outcomes report and discuss site goals around quality improvement. Annually, the project's Nurse Consultant will visit the site in person to have the opportunity to observe a team case conference and do an agency implementation review which includes looking at all the fidelity elements of the program and assessing how well the site is doing implementing the program with fidelity to the model. A fidelity report that provides data on many of the 18 model elements is reviewed quarterly and during the site visit as well. The NSO can offer consultations from other internal departments such as Human Resources, Marketing, and Quality, as needed as well. The NSO education team has a series of in-person education sessions, webinars, and self-paced online modules to support NFP staff in learning the model and fully integrating skills such as motivational interviewing and reflective practice into their professional practice. Educational supports are added as needed. During the annual site visits, time is dedicated for team education as well.

Early Head Start: The Office of Head Start (OHS) monitors fidelity of Head Start and Early Head Start programs with a five year Aligned Monitoring System. This process gives OHS a multi-year perspective on grantee performance with a focus on high quality and compliance. The Aligned Monitoring System offers intensive examination of performance in the following core areas:

- Environmental Health and Safety
- Leadership, Governance & Management Systems

- Fiscal Integrity/Enrollment, Recruitment, Selection, Eligibility and Attendance
- Comprehensive Services & School Readiness
- Teacher-Child Interactions

The OHS has regional technical assistance centers that are assigned to support and offer on-site technical assistance to grantees when requested. Group trainings and annual regional conferences are offered as well.

Child First: The Child First National Program Office (NPO) CT Clinical Director meets every two weeks with every Child First affiliate site's Clinical Director/Supervisor for reflective, clinical consultation where difficult cases and supervision challenges are discussed. The NPO Data Department ensures that all sites have access to monthly implementation (process) data reports to gauge against model requirements and quarterly assessment outcome reports to assess impact on families. This data is reviewed by the CT Clinical Director with the site Clinical Director on a monthly basis. Together, they discuss possible improvements, including "small tests of change" to enhance model delivery. They may also discuss staff management issues and progress on quality enhancement goals. In addition, the NPO provides monthly reports to the OEC to provide updates on staffing and other implementation issues.

The Child First NPO offers specialty training and holds an annual conference as ongoing training. For instance, in July, 2015 all Child First Clinical Directors attended a three day training to strengthen their reflective supervision skills. New staff have access to Child First's online Distance Learning and are also expected to attend a full Learning Collaborative when offered. There is a CT Learning Collaborative currently in session.

PAT: ConnPAT (Connecticut Parents as Teachers) has its own Parents as Teachers National Trainers (ConnPAT Training Team) with a Training Coordinator who assists site staff in registering and attending the trainings. ConnPAT offers four Foundational/Model Implementation trainings each year to accommodate new staff; in addition, trainings can be added as required for large numbers of incoming staff (for example newly funded initiatives or additional sites). At least two Foundational 2 trainings are offered each year to accommodate staff who are providing services to families with children aged three years through Kindergarten. ConnPAT offers technical assistance in many ways to accommodate the varying needs of affiliations and staff. The State Leader, Training Coordinator/Curriculum Technical Assistant and Model Technical Assistant are available through email and by phone for quick assistance. Other communication and information are available through monthly conference calls open to all affiliates, and the ConnPAT web site (www.connpat.org). For more detailed needs ConnPAT staff will attend meetings, workshops, etc. to provide data, specific procedures, assistance with curricula, or to meet other needs of PAT staff. The ConnPAT State Leader is available as liaison with National Parents as Teachers staff in order to facilitate issues or questions that arise about certification, renewals, fees and any other areas of affiliation or staff need.

Plan for Sustainability The state has made a strong commitment and significant investment in evidenced based home visiting. It will use its available resources to pursue three funding strategies to sustain the program, listed below.

Social Impact Financing: The OEC will explore the use of social impact financing to sustain funding and maintain services provided through the MIECHV program. To do this, the OEC will study the large scale implementation of the PAT and Child First home visiting programs in CT and elsewhere, to determine their positive impacts on early childhood outcomes including child maltreatment and the health and development of children. It will determine whether these positive outcomes would save remediation costs, publically funded by the state and other parties concerned about the well-being of children, including private foundations. If the study shows significant cost savings from the MIECHV programs, the OEC and its partners will pursue funding to sustain the program through the use of a 'social impact bond' and other social funding vehicles. Through the use of a social impact bond, private investors and other funding partners provide the initial capital to scale up successful programs usually funded by government agencies. Under this funding approach, the government does not pay for the expansion; instead it pays for agreed upon outcomes. The social impact bond resolves the common problem of limited government funding–government entities not having sufficient resources to expand proven successful prevention programs–by procuring capital from private sources.

Medicaid Reimbursement: The OEC discussed Medicaid reimbursement as an option for funding the MIECHV program with the Medical Policy Unit at DSS. They found that for a number reasons, MIECHV services are not eligible for reimbursement. However, they noted that Medicaid might be an option in the future. In response to the Affordable Care Act certain preventative and administrative services as recommended by physicians or other licensed practitioners may be covered. DSS is expecting guidance from the Centers for Medicare and Medicaid (CMS) and agreed to explore this option further at that time. In addition, Child First has been working with DCF and DSS to establish Medicaid reimbursement for eligible children. Most recently, we learned through the MIECHV sustainability calls that Medicaid is open to proposals for reimbursement. The OEC will pursue this opportunity as well. If the regulations permit, Medicaid is a viable option for CT. The state's total investment in evidenced based home visiting is roughly $14 million. At a reimbursement rate of 50% the state would net $7 million which would largely cover the cost of sustaining the MIECHV programs.

State General Fund: While CT has struggled with budget reductions over the past several years, it has continued to make significant strategic investments in early childhood programs and services. It is not unreasonable to propose that the Governor and the CT General Assembly consider state general funds to sustain the cost of the MIECHV program when the grant ends. When the state-funded PAT program began with just $300,000 dollars several years ago no one envisioned that the budget would grow to be $10.4 million today. Similarly, Child First began with philanthropic dollars and now has a state budget of approximately $4 million. Given the value and importance of home visiting in CT it would be worth pursuing this option. As the MIECHV programs build their presence in communities across the state and show positive impacts for families it is likely that the State will want to maintain these services.

LOGIC MODEL – See ATTACHMENT 1

WORKPLAN

TIMELINE – See ATTACHMENT 2

Total Proposed Caseload of Family Slots: The total proposed caseload of family slots for the final six months of FFY 2016 (April 1 - September 30, 2016) is 947. For fiscal year 2017 the proposed caseload of family slots is 1,086 per year, and for FFY 2018, it is 883 slots.

Budget Estimated Expenditures to Support Direct Services:

	Amount	% of grant
State Level Salary and Fringe	$474,984	5%
Travel	$25,000	<1%
Child First, Inc. Administrative Costs	$229,905	2.5%
Supplies	$6,000	<1%
Training	$12,000	<1%
Other	0	0
Direct Service	$8,352,111	92%
Total	$9,100,000	100%

Table Identifying Local Implementing Agencies: see ATTACHMENT 9

Cost per family: The cost per family was calculated by dividing the contract award to the local implementing agencies by the contracted total of number of families to be served per year. Factors that influence the cost per family are related to the staffing and program delivery requirements of each model, as well as their model fees. In Connecticut, we use four different evidence based home visiting models. Early Head Start and Parents as Teachers employ home visitors with a minimum of an associate degree, experience working with children, and with the expectation that they will provide weekly visits. Nurse-Family Partnership employs nurses and provides bi-weekly visits. The Child First model uses a team approach and employs bachelor-level care coordinators and masters-level clinicians to provide weekly visits. The model developer fees also vary from model to model. The annual Parents as Teachers affiliate fee (includes Head Start) is $1,500 plus $150 per certified user. The annual Child First affiliate fee is $6000.00 for one team and $12,000.00 for sites with 2 teams. The annual Nurse-Family Partnership program support fee is $7,400, with an additional annual nurse consultation fee of $8, 989.

Changes from 2015 to the 2016 Budget:

- **Reduction of 1 state-level staff position:** The duties and responsibilities performed by the current Health Program Associate are primarily fiscal and contracting duties. Beginning April 1, these duties will be covered through the Central Contracts Unit, the OEC fiscal office, and the OEC state-funded Family Support Services Program Director. The State of Connecticut Central Contracts Unit is responsible for managing the administrative, fiscal, and contracting functions related to health and human service contracts at CT Office of Early Childhood. Sarah Poulin, Associate Fiscal Administrative Officer for OEC will assist the MIECHV Program Liaisons and the MIECHV Program Manager in monitoring the use of funds and providing technical assistance related to financial reports and budgets. The OEC

Family Support Services Division Director, Linda Harris will assume overall responsibility for monitoring the financial aspects of the MIECHV program with a primary focus on sub-recipient contracts.

- **Elimination of funding for centralized call center:** MIECHV funding for the centralized call center, Child Development Infoline and the Help Me Grow system, will be eliminated. The Family Support Services division of OEC currently provides state funding for both of these services. Therefore, MIECHV programs will still have access to both services and there will be no impact for the MIECHV programs.

  There will be no changes to the 2015 budget.

RESOLUTION OF CHALLENGES

The replication and enhancement of the PAT, NFP, EHS and Child First evidenced based home visiting programs, particularly at a large scale, present a number of important challenges. To bring the programs to the next level, where they are highly effective and well-integrated in the community, 'buy-in' is needed from a significant number of stakeholders at the state, local, organizational, community, and neighborhood level. This will require that everyone involved has a clear understanding of how the programs work, why they are valuable, and how they need to be supported. The large number of people and organizations involved in this effort also present logistical and communications issues. To address the challenges of program expansion the following principles will be observed:

Core services and program implementation strategies are well understood and communicated. Strategy: Provide clear information about the program philosophy, values, approaches and intended outcomes of the evidenced based practices to all parties implementing the program and all of the partners we are seeking to engage. Opportunities will be made through the Home Visiting Consortium, which serves as the MIECHV state advisory committee, for presentations and discussion of the theoretical underpinnings of the models, their approaches to providing human services in diverse and at risk communities, and their evidence base.

Component parts of the program are well coordinated and communicated effectively Strategy: Inform all stakeholders about the scope of the entire plan. Invite feedback and open discussion about how various aspects of the program work together to coordinate efforts. Solve problems and adjust course as issues emerge.

Other challenges include the retention of families that tend to be highly mobile and transient, those who speak a language other than English (either primarily or solely), and those who may be living in households with others. Each of these circumstances make home visiting challenging. To address these challenges, the OEC will look at ways to provide services as quickly as possible, and as comprehensively as possible, in ways that are consistent with family need and receptiveness. Another strategy will be to work with partner organizations who work with refugee families and/or families whose first language is not English. Partnering with such organizations will help OEC staff develop strategies for working with these families who have additional challenges. Further, reaching out to cultural organizations may also help in creating a

more linguistically diverse workforce.

The OEC will work with HRSA, the national model developers, and others to request technical assistance and support in resolving the challenges associated with engagement and retention, including information about strategies that have been shown to be successful in other states. Part of the examination of retention will be to look at the literature, and Connecticut's own data, to illuminate the strengths and particular contributions of each model. Goals for retention will be considered in relation to goals of the program model, and, if possible, to goals of the families.

PERFORMANCE, TECHNICAL SUPPORT CAPACITY, AND EVALUATION

Performance Management: The Office of Early Childhood MIECHV staff directed the design, build, and roll-out of a custom web-based data system to collect form one (client demographics) and form two (benchmarks) information. Three of the four program models (PAT, EHS and NFP) use the dedicated MIECHV database. Child First LIAs use Excel spreadsheets, and submit them to the Office of Early Childhood. To report Form One and Form Two data in the DGIS system, two working reports are generated: one for PAT, Early Head Start, and Nurse-Family Partnership combined (because they are all included in the MIECHV database), and one for Child First. These two reports are then combined to form the final dataset that is entered into the DGIS system.

Form one and form two data reports are required on a quarterly basis from each LIA, covering the periods January-March, April-June, July-September, and October-December. In addition to the data reports, progress reports are required for the same quarterly periods. Taken together, these reports give a thorough picture of each program's performance, including number of new and continuing households served (from which % capacity can be derived), zip codes served; status of benchmark collection, family engagement and retention, and staff recruitment and retention.

Tremendous progress has been made over the course of the last year in improving data collection state-wide, particularly as it relates to the benchmarks. The database had been brand new at the time of data collection for FY 2014; over the course of the following year, many changes and clarifications were made to the database in time for the FY 2015 data submission. In addition to the technical improvements, many other initiatives improved data collection. Meetings were held with home visitors, supervisors, and program managers to clarify the expectations around data collection; specifically the exact information that was to be gathered, including how and when, and where it should be recorded in the database. Forums were held so that LIA staff could share difficulties that they were having, and solutions could be discussed and agreed upon. Outcomes and follow-up and from these meetings included a series of trainings, a reference document, paper forms, further refinements to the database, and ongoing TA– all with the goals of standardizing data collection across the state and improving data completeness and accuracy.

Continuous Quality Improvement Plan: Background The MIECHV grant was transferred to the OEC from the state Department of Public Health in January 2015. Prior to the transfer, the OEC was operating an existing, large, state-funded Parents as Teachers program serving roughly 2,200 families a year. State-funded program staff had developed a Continuous Quality Improvement (CQI) process in 2003 to ensure the effective implementation of this program. The

process encompasses CQI activities at the state level or "network" level as well as at the local implementing agency level. The OEC has developed a three tiered plan for integrating the MIECHV programs into this process.

The first tier involves fully integrating the 14 MIECHV-funded PAT programs (this includes the Early Head Start site which is also a PAT affiliate) into the CQI process. The second tier involves using the CQI process at the local level with Nurse-Family Partnership (NFP) and Child First administrative and direct service local implementing agencies. The third tier involves the establishment of a state-level infrastructure that will serve as a forum for CQI across *all* models and staff funded by the MIECHV program. While this is being developed, the Child First administrative agency and NFP programs will use CQI systems they have established for the models in coordination with the state's benchmark improvement plan and lead agency staff on policy related matters.

Tier One - Fully integrating the 14 MIECHV funded PAT programs, including EHS, into the CQI process: Central to the Continuous Quality Improvement process is a "CQI Team" and a results based accountability framework. The existing CQI Team has been developed with and among the PAT local implementing agencies, OEC staff, and program evaluators. The team meets on a regular basis to address issues identified by the researchers, interpret data, and inform policy. The goal of the CQI team is to ensure that home visiting practices can be assessed and adapted based on advances in the field and findings from the Office of Early Childhood's own research, and the 'real time' experiences of home visiting staff.

At this time, the OEC has integrated its 13 MIECHV-funded PAT programs and is working to integrate its one Early Head Start program (which uses the PAT curriculum) into the CQI process at both the state and local levels.

The Continuous Quality improvement Team: The Continuous Quality Improvement Team (CQI) includes representatives and alternates from local agencies implementing PAT. The PAT programs (about 50 in total, including MIECHV) are organized into five regional networks across the state. The CQI team members are elected from these regional groups to represent their staff role and serve on the CQI for two years. The team meets on a regular basis. It functions as a "mini-Congress" where program implementation questions, problems, and quality assurance issues are addressed. The CQI team meetings provide a vehicle for thoughtful and consistent discussions between the OEC staff, researchers, and program administrators, as well as supervisors of the home visiting program and front-line staff. Matters raised at the CQI Team meetings are brought to regional groups for discussion and often a vote. In this way the CQI process gives every staff member a voice. The discussions and subsequent policy recommendations have been essential to bringing research and practice together, developing a collective understanding of the model, and helping staff adhere to its practices.

Discussions with the CQI Team have helped to clarify the philosophy behind intervention strategies and helped illuminate policies and practice standards by considering them within the context of real life situations that need to be addressed in the field. For example, the CQI Team has developed policies and practice standards for the role of the clinical supervisor, staff training

and the credentialing of home visitors, and an in-service training model that connects issues and challenges raised in clinical supervision with professional development.

Program staff at all levels had much to contribute to the development of the model, policies, and practice. Through the CQI Team, program staff is able to review research findings, evaluate and test policy recommendations, and help make changes to improve practice. This process also enables the OEC to scrutinize the research findings and to bring new ideas and innovation to the program by keeping it dynamic and responsive to challenges involved in home visiting while maintaining fidelity to critical areas of the program. The OEC staff is responsible for managing the CQI Team, chairing the meetings, staffing the sub-committees, drafting the policies, and facilitating the flow of information throughout the network. To implement new policy and program changes, the OEC staff worked with staff at the program sites to provide training, examine program outcomes and make recommendations. OEC staff also worked with on-site staff to solve problems.

Bringing evaluation data, research and performance measures to CQI: The CQI Team uses a wide range of information to inform program policies and a set of best practices to guide the development of the home visiting program within the individual sites and within the statewide network of sites. This information includes annual evaluations, ethnographic studies, and other research conducted on the state-funded PAT program by the University of Hartford, studies conducted on other home visiting programs, and now, the MIECHV benchmark data and fathering home visitor evaluations. For example, its work has included developing theoretical models to better understand and describe how program goals and policies translated into effective practice in a variety of settings; the ways barriers to successful implementation could be overcome, and effective strategies to administer the program in the "real world" context of large hospitals and small community-based organizations. The CQI Team has used ethnographic studies, research and evaluation on the program to understand about the dynamics of the sites—how they worked and what made them effective. The CQI Team has reviewed "family life stories", in-depth interviews with more than 200 families, to gain insight into the families involved with the programs—who they were, why they became involved, and ways in which the service was relevant to their lives.

The main source of data has come from a contract the OEC has with the Center for Social Research at the University of Hartford to evaluate the state-funded PAT home visiting program. The Center's work focuses on three key domains:

1. Annual data collection to measure program outcomes in areas the program was trying to impact.

2. Ethnographic studies to develop an understanding of home visiting practice, the functioning of the sites, and the families participating in the program.

3. Quality assurance measures to assess individual site performance and the overall performance of the network.

OEC has also contracted with researchers at the Center for the Study of Culture, Health, and Human Development at the University of CT (UCONN) to evaluate its training program for

home visitors, and with others to study other aspects of the state funded PAT home visiting program.

Process and Outcomes: The CQI Team, which includes the researcher, meets to discuss and analyze findings. Out of these, meeting policy and practice decisions are made. Examples include:

The researchers conducted an ethnographic study of 171 mothers participating in the state-funded PAT home visiting program and found that the program was working with 4 distinct groups of mothers, each with very different needs. Of those in the study, 12% of the mothers had cognitive impairments, 23% of the mothers were young, between the ages of 13 and 16, and 33% of the mothers were living in ongoing crisis. The fourth group, 32%, was found to be living in some but less distress due to linguistic and social isolation or histories of mental illness and/or substance abuse that were being or had been treated.

These findings made it clear that a "one size fits all" approach to services was not appropriate. In response, the program adopted a "case by case" approach to scheduling home visits with families, rather than prescribing a predetermined two or four visits per month for every family. Caseloads were determined by a weekly home visiting schedule based on the needs of the families rather than by visiting a fixed number of families. By using this approach, each home visitor's caseload reflected the number of home visits required for each family. Policies to address the various circumstances of the families were also developed. These included policies for working with mothers in crisis, working with mothers who were dependent on others, and working with mothers with cognitive delays or other developmental disabilities. The policies provided guidance to program staff working with mothers in these circumstances and created a framework for decision making within the program. The OEC's current research efforts include addressing maternal depression in the mother's home and engaging fathers within the current home visiting model.

CQI Team Structure: Elected Membership: Staff Representatives and Staff Alternates are elected by their peers for each staff role (home visitors, clinical supervisors, program managers, group facilitators, and outreach, or "connections" staff) from each region for a two year term, with the possibility of serving for two consecutive terms. The expectations for each Staff Representative are outlined below. In the absence of the Staff Representative for a given region/role, the Staff Alternate will assume all roles and responsibilities.

- Attend scheduled CQI and regional network meetings
- Voting member of CQI (on behalf of the region)
- Serve as liaison between CQI and program staff in the region
- Communicate program ideas, challenges and matters to be addressed
- Lead efforts (sets schedule, secures meeting location, notifies staff, creates agenda, facilitates meetings, develops minutes, communicates with Program Liaison) to create regular network opportunities in the region
- Collaborate and communicate closely with *Staff Alternate* to facilitate effective representation of their peer constituents in the network.
- Counts as Professional Development opportunity

Non-Elected: the Chair and Co-Chair of CQI are designated OEC staff. Chairs are not voting members of CQI and help coordinate and facilitate discussions and process. Research and Evaluation staff are members of the research and evaluation team and are voting members of CQI. Guests include all other staff and individuals that participate at a CQI meeting. Guests are non-voting but can have time designated to take part in conversation.

CQI Team meetings occur two times per year, and may meet more frequently as necessary, for example quarterly, as priorities arise. Regional Network meetings are coordinated by CQI Representatives and/or Alternates in collaboration with peer staff in their region. Regional meetings should occur on a regular basis with a minimum of twice per year. Guests include all other staff and individuals that participate at a CQI meeting.

In addition to regional and state-wide CQI Team meetings, there are two full-day meetings annually for the entire NFN network. These meetings are considered professional development. The content includes:

- Business, including votes on new policy
- Share research and data
- Professional development and education
- Networking (breakout sessions)

Tier Two-- Local CQI process: The local CQI process is being implemented with all four of MIECHV models and their 23 LIAs. The FSS staff works with every local implementing agency each year to develop an Individualized Program Plan. The plan identifies areas of strength and those in need of attention or improvement, and strategies for achieving identified goals. The FSS staff schedules a site visit with each local implementing agency to discuss the program. The LIA is encouraged to bring an advisory committee member, board member or director from the organization to the meeting.

The LIAs submit a report to the FSS staff on their program at least two weeks prior to the site visit. The report should include information on the program and the efforts of any subcontractors, including:

- A current staffing plan
- List of advisory committee members and a summary of committee activities
- A description of their work with other organizations within their community, noting any formal or informal agreements
- A summary of progress made on the site's Individual Program Plan over the past year
- A Results Based Accountability Report Card (RBA).

The University of Hartford and the MIECHV epidemiologist forward the most recent data and RBA template to the LIAs. The LIAs are encouraged to involve all program staff and their advisory boards in the process of developing the RBA report card, which uses current data, along with data from the previous two years. Based on a review of the RBA and information obtained during the site visit, and recommendations from the FSS Staff, the LIAs create an individualized

program plan for the upcoming year. The plans are submitted, discussed, and approved by FSS staff. Progress is reviewed on a quarterly basis throughout the year.

Below are the instructions given to the LIAs to use in developing a Results Based Accountability report card:

1. Identify members of the agency staff who should have input into the report card for the selected program. This should include staff associated with the program itself, but may also include other budget, data analysis, and policy staff. Although program staff should be involved in developing the report card, the executive leadership of the agency is ultimately responsible for the report card, and should be prepared to present and discuss the report card.

2. Describe how the program contributes to the result listed in the template: **All young children in CT will have nurturing parental care that meet their needs and will be healthy, developmentally on track, and ready to learn.**

3. List the actual amount of state, federal, and other funding, as well as total funding, for the current fiscal year.

4. Identify the partners that have an important role to play in improving the program or leveraging the program's contribution to the result.

5. Present no more than three important "How Much" measures, a measure that shows how many customers the LIA has served or services the LIA has delivered.

6. Present two or three important "How Well" measures, measures that show how well the LIA is operating the program.

7. Present two or three important "better off" measures, measures that show whether customers are better off after receiving program services or as a result of program activity.

8. For each measure, provide a brief narrative (in the space allowed in the report card template) explaining the story behind the baseline. This should focus on your diagnosis of why performance is where it is for the measure. You should also explain any problems with the data. Do not merely describe what the chart shows unless there is a need to clarify something.

9. For each measure show three years of data. Using one of the arrows, indicate whether for each measure the trend is going in the right direction ▲ or the wrong direction ▼, or if the trend is flat or there is no trend ◄►.

10. In the last column of the report card, identify a small number of actions the LIA will take to improve program's performance or mitigate the effect of budget cuts on the LIA program; include low-cost or no-cost actions or reallocation of existing agency resources.

11. Use the Data Development Agenda in the last column to list new or improved data analysis tools that the LIA intends to develop for any of your existing measures or for new measures that are needed.

12. Submit the report card to the Office of Early Childhood program liaison at least two weeks prior to your site meeting.

Tier Three-- Across Model State Level CQI process: During the upcoming year, the OEC will design and establish a process that involves all four models in a CQI process to evaluate and address policy and practice matters that cut across all of the models. While this process is being developed, we will work with PAT and EHS sites through the established CQI Team, and work with Child First and NFP separately.

The policy issues addressed through this process will include findings that result from the sites' involvement in Tier 1 and Tier 2–including a few matters that have already begun to emerge. These emerging issues include ensuring that family participation in the program is always voluntary, working with homeless families, working with families with multiple children, protocols for working with Connecticut's child welfare agency, procedures and best practice for families on waiting lists, and benchmark improvements. In the next year, and after HRSA releases the new DGIS system and benchmark constructs, we will begin the work of integrating MIECHV data into the Early Childhood Information System under development at the OEC.

The current CQI plan was approved in November 2015. OEC staff will provide an updated plan within 90 days of an issuance of a Notice of Award.

Evaluation: There are no completed evaluation reports supported by previous MIECHV funding at this time.

ORGANIZATIONAL INFORMATION

The State Lead Agency - The Office of Early Childhood: The CT Office of Early Childhood (OEC) is the state agency charged with overseeing a coordinated system of early care and education and family support. This agency is well positioned to meet the goals of the grant, to effectively carry out the proposed activities, and embed the program within a comprehensive, high quality early childhood system. The OEC has a laser-focused mission to support families with young children; it has established a coordinated structure that pulls together staff with experience from across the early childhood system; and it has the resources, expertise, and support from the Governor and state legislature critical for the long-term success of this program.

Mission and Vision: "All young children in CT are safe, healthy, learning, and thriving. Each child is surrounded by a strong network of nurturing adults who deeply value the importance of the first years of a child's life and have the skills, knowledge, support and passion to meet the unique needs of every child". The OEC was created to make this vision a reality. The OEC's mission underscores its focus on building an integrated early childhood system. It reads "The Office of Early Childhood's mission is to support all young children in their development by ensuring that early childhood policy, funding, and services strengthen the critical role families,

providers, educators, and communities play in a child's life". Ensuring the availability of high quality home visiting programs is a critical activity to support this mission. Over time, expertise developed in separate agencies over many years will become synthesized and enrich the system as a whole. As a small example, a screening tool (the Ages and Stages Questionnaire) long utilized by Help Me Grow and the home visiting programs, is now part of the early learning standards for childcare.

Structure: The OEC is structured with the appropriate programs, legislation, management, stakeholder support, committees, strategic plans, data systems, fiscal controls and priorities, partnerships, funding, and culture to effectively support home visiting quality and embed it within a the larger early childhood system of CT. (See ATTACHMENT 11- OEC Organizational Chart). The four divisions within of the OEC are: Early Care and Education, which focuses on the early childhood workforce, supports program improvement, and helps families access high quality early learning experiences; Child Care Licensing monitors child care programs and youth camps to ensure centers operate at or above the required standards, including health and safety; Family Support Services works to strengthen families to ensure positive child development; and Early Intervention Division manages the IDEA part C program to support the needs of children with disabilities or delays from age zero through two.

Additional home visiting infrastructure structure: The FSS division has a highly trained and experienced staff in the field of home visiting. Since 1995 it has successfully developed and administered a large evidenced based home visiting program and developed an infrastructure that is well suited for achieving the purposes under the grant. The FSS staff has designed and facilitated a high quality training and credentialing program for home visiting program staff; worked in partnership with academic centers that have conducted evaluations and research on its programs; and provided feedback that has been used to inform and refine practices as the program has developed; and established a quality assurance process to oversee and ensure adherence to best practices and quality services. Going forward, the FSS will benefit from the early childhood data system that will allow the program to better understand the needs of the families they are serving, especially as it will provide information on additional services families are receiving.

Recruitment and Qualification of Staff: The program models set standards for the qualifications of home visiting staff. Staffing plans and the organizational structure for the programs are reviewed as a part of the contract process and at the annual sit visit. In addition, CT ensures that these standards are met by requiring the LIAs in their contracts to submit resumes for all new staff. The LIAs are responsible for recruiting staff from within their communities that meet the qualifications and are well suited for a job within the home visiting program. CT includes a discussion of the need for both 'hard' knowledge-based and 'soft' interpersonal-based skills in its training for managers and supervisors.

Use of Data in Determining Training Needs: Each of the models has developed training requirements needed for staff to implement their home visiting models. The scope of these requirements varies by model, with Child First having the most extensive and comprehensive training program. CT has augmented the training for PAT and EHS to address areas not covered by the models. These trainings enhance human services skills through a strength based approach,

and cover a wide range of topics, including: reflective supervision; infant and early child development; identifying and working with potentially harmful or inappropriate parental expectation and attitudes toward children; and gender-specific approaches for working with mothers and fathers; working with special populations; and a program of ongoing professional development at the LIA-individual staff level. These trainings were selected based on formal and informal feedback from home visiting staff and a review of the knowledge and skills required for their complex roles. The training program was studied and evaluated by the University of Connecticut Center for Study of Culture, Health and Human Development. The study found the training to be effective in enhancing knowledge of infant and child development, the perspective and understanding of the complexity of families, building a cohesive supervisor-home visitor team, and professionalizing the role of the home visitor. We will spend time reviewing the training and training needs of the NFP program this year.

Training Program: The training program is described earlier in this application.

Supervision: CT ensures high quality supervision by requiring that supervisory staff have a master's degree in social work or a related field as a minimum qualification. In addition, CT uses a reflective supervision approach throughout the program models and provides training for supervisory staff in reflective supervision. Supervisors also participate in the model developer training and additional training to support effective supervision offered by the OEC.

Reflective Supervision: Families who participate in the home visiting programs have complicated lives and complex needs. Providing services for these families presents many challenges for all staff. Clinical supervision assists home visitors to address the complicated issues, as well as the experience of the home visitor working in their families' homes. A master's level clinical supervisor provides reflective supervision one-on-one, in groups, and in joint home visits. In addition, the clinical supervisor performs several administrative tasks, teaches new skills, supports the professional development of the home visitor, and helps them to work through their feelings and reactions to their challenging work with families.

Resources and capabilities to support culturally, linguistically and health-literate services: The OEC is exploring opportunities to develop the capability of the LIAs to meet the cultural, linguistic and health literacy needs of the families. This year the OEC will be reaching out with the LIAs to the community organizations that have developed to provide services, social engagement, religious services, and support to refugee and immigrant populations throughout the state. The purpose will be to better understand what these groups have to offer, get their recommendations on how to address these needs, and develop a working relationship to address these needs.

Organizational capacity of any partnering agencies involved in the implementation of the project: Child First has a National Program Office located in Shelton, CT with professional staff dedicated to training, clinical consultation, quality enhancement, data collection and analysis, finance management, and an administrative structure to manage the contract with the State of CT OEC and the subcontracts with the MIECHV-funded sites. Over the past four years, Child First has demonstrated its capacity to successfully replicate its evidence-based model with high quality implementation and outcomes. This has required developing extensive training, ongoing

technical assistance, and strict accountability to fidelity. Child First is actively involved in numerous collaborative efforts throughout CT including the Early Childhood Alliance and the CT Association for Infant Mental Health, and it has worked closely with other home visiting model developers, including Nurse-Family Partnership, PAT, Healthy Families, and HIPPY at the national level.

Commitment and Resources: CT has demonstrated its commitment to evidenced based-home visiting as demonstrated by its significant investment and effort to support the state funded PAT program, federally funded Early Head Start collaborative office, the IDEA (part C) program and now the MIECHV program. Through the Home Visiting Consortium, the MIECHV State Advisory Committee, the ECCS, and the CBCAP Prevention Partners for Children, the OEC assures that the goals, objectives and activities of the project will not only be incorporated into its efforts, but the efforts of these groups, and the partners and stakeholders will be prioritized and maintain after the grant period ends. Funding is not available to support the program at this time, however, the groups mentioned above and others, have expressed a strong commitment to ensuring the continuation–and if possible–expansion of home visiting services.

PAST PERFORMANCE AND ADMINISTRATION OF HOME VISITING PROGRAM

Connecticut has met previously projected family enrollment and retention goals in the 2014 and 2015 competitive and formula grants. However, barriers exist in retention and recruitment particularly for one PAT and one Child First LIA located in rural eastern CT, and for one NFP program located in small town along the CT coast. CT will provide intensive technical assistance to these programs drawing on methods and strategies that have been shown to be effective in other rural districts. It will also adjust enrollment eligibility for one its state-funded PAT programs to allow for the NFP program to have access to an adequate number of families in the community that meet their narrow window for enrollment.

Improvement plan progress: CT was placed on an Improvement Plan in April, 2015 for not meeting overall improvement in four of six benchmark areas for the period of October 1, 2013 to September 30, 2014. CT made significant progress on the benchmark data since that time through a concerted, multi-faced effort that included meetings with LIA staff at all levels (home visitors, clinical supervisors, program managers), creation of a reference document and paper forms, refinements to the database, a series of trainings, and ongoing TA. For the benchmarks for the period of October 1, 2014 to September 30, 2015 CT showed improvement in all six benchmark areas as a state, and among each program model.